(the election period). This subsection of Section V of Attachment 4.19-A describes the optional payment rate methodology for inpatient hospital care.

The optional inpatient hospital prospective payment rate will be a per diem rate that is based on the facility's approved inpatient hospital Medicaid rate and the department's rate analysis for the facility's fiscal year that began during the period January 1, 1997 to December 31, 1997 (rate base). The prospective payment rate is composed of separate capital and noncapital portions. The capital portion is calculated by dividing the facility's Medicaid capital per adjusted admission in its rate base by the average Medicaid length of stay in the base year. The noncapital portion is determined by dividing the facility's allowable Medicaid costs per adjusted admission in its rate base by its average Medicaid length of stay in the base period and subtracting the calculated capital portion. The noncapital portion will be increased at the rate of three percent per year annually for each complete fiscal year that begins after December 31, 1997. The daily per diem rate is limited to charges for each patient in the aggregate and therefore the system will pay the number of allowable days billed at the established rate no matter what the charge.

The department will allow an increase in the capital component of the prospective payment rate for new assets valued at $5,000,000 or more that the facility places in service during the election period and for which a Certificate of Need was obtained. The facility must submit a detailed capital budget that reflects the estimated allowable costs for the new assets in service during the prospective rate year.

Prospective payment rates determined for the small facility, for certain years, must include an appropriate year-end conformance adjustment in accordance with Section V The year-end conformance adjustment for a small facility with a fiscal year that ends June 30 is calculated based on the fiscal years of the small facility that end on June 30, 1996, June 30, 1997, and June 30, 1998; and applies to the rates for the fiscal years of the small facility that end on June 30, 1999, June 30, 2000, and June 30, 2001, respectively. For a small facility with a fiscal year that ends December 31, the year-end conformance adjustment is calculated based on the fiscal years of the small facility that end on December 31, 1995, December 31, 1996, and December 31, 1997; and applies to the rates for the fiscal years of the small facility that end on December 31, 1998, December 31, 1999, and December 31, 2000, respectively. No year-end conformance will be calculated on base years whose rates were calculated under this subsection.

Facilities electing to be reimbursed under the Optional Payment Rate Methodology shall use the administrative appeal process described in Section VIII if the facility disputes an action or decision of the department that relates to:

- the facility's eligibility to make this election;

- a violation of a term of the agreement between the department and the facility;

- a year end conformance adjustment calculation applied during the election period;

- a denial of a CON increase in the prospective payment rate made under this election.

VI Sale of Facilities:

An appropriate allowance for depreciation, interest on capital indebtedness and (if applicable) return on equity capital for an asset of a facility which has undergone a change of ownership will be valued at the lesser of the allowance acquisition cost of the asset to the owner of record on or after July 18, 1984, or the acquisition cost of the asset to the new owner in accordance with Section 1861(v)(1)(O) of the Act. In addition, the recapture of depreciation expense on disposition of assets that accommodate gains under the Medicaid program will be limited by the provisions of Section 1861(v)(1)(O)(ii) of the Act. Payment for acquisition costs associated with buying and selling of the facility will be limited by the provisions of Section 1861(v)(1)(O)(iii) of the Act.

VII Adjustment to Rates:

All rates for facilities are set by the department with the advice of five Governor appointed Commissioners. The Commissioners are: a representative of the State of Alaska, a representative of the providers, a physician, a certified public accountant, and a consumer. Facilities have the opportunity to provide additional information on significant changes that would impact the rates.

The department on its own motion or at the request of an applicant may reconsider its actions within 30 days. There is nothing to preclude a facility from petitioning the department at any time during its fiscal year for additional consideration.

Reconsiderations are warranted only in those cases where the proper application of the methods and standards described in Attachment 4.19-A is in question or is being challenged.

VIII Provider Appeals:

If a party feels aggrieved as a result of the department's rate setting decisions, the party may appeal and request reconsideration or an administrative hearing. Administrative hearings are conducted by Governor appointed Hearing Officers. An administrative appeal must be filed within 30 days of the mailing of the decision of the department.

The Hearing Officer would hear a case in accordance with administrative law in the State of Alaska. The Hearing Officer would prepare draft findings, conclusions and order for

the commissioner of the department's review. The commissioner of the department would review the findings of the Hearing Officer and may accept, reject, or modify the Hearing Officer's recommendations. If a party still feels aggrieved at this point, judicial review is available to contest actions of the department and the rate set.

IX Audit Function:

The Department has statutory authority to audit data relating to Medicaid prospective payment rates. Audit findings that would affect the prospective payment rates are adopted by the Department and incorporated into future prospective rate calculations. This means that even though an audit is not completed before a subsequent year has passed and retroactive recoupment from the facility will not take place, the results of the audit will be incorporated into the rate calculations relating to future prospective periods as applicable.

X Inappropriate Level of Care:

Payment for hospital patients receiving service at an inappropriate level of care under conditions similar to those described in Section 1861(v)(1)(G) of the Social Security Act will be made at lower rates, reflecting the level of care actually received, in a manner consistent with Section 1861(v)(1)(G). The payment rate will be the average statewide rate for swing bed days. The state uses the same methodology for SNF services and ICF services, and does not differentiate between the different types of services. The swing bed rate is a composite rate weighted by patient days and is a summation of each facility's payment rate for the preceding calendar year multiplied by patient days of each facility and then divided by the total patient days of all SNF/ICF facilities. The swing bed rate is determined and approved by the Department prior to the beginning of the calendar year and is based, where applicable, on estimated data.

The state continues the policy of paying the lower rates to inpatient hospitals when the patient receives care at either the skilled or intermediate level nursing services with no exceptions.

XI Hospitals Serving A Disproportionate Share of Low Income Patients:

Hospitals serving a disproportionate number of patients with special needs will receive a payment adjustment based on the following criteria:

(1) Determination of Eligibility. (a) The hospital's Alaska Medicaid inpatient utilization rate, (as described in Section 1923(b)(2)), is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State of Alaska, (the "mean" of Medicaid

inpatient utilization rates for all hospitals in the state is the fraction, expressed as a percentage, of which the numerator is the total number of inpatient days for Medicaid-eligible patients for all hospitals in the state and the denominator is the total number of inpatient days for all hospitals in this state) or (b) the hospital's Alaska low income utilization rate, (as described in Section 1923(b)(3)), exceeds 25 percent. To determine eligibility under (1)(a) and (1)(b), data from the hospital's qualifying year as described in this section at (12) will be used.

For purposes of (1)(a), the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the State plan, and the denominator of which is the total number of the hospital's inpatient days. The standard deviation of Medicaid inpatient utilization, will be calculated by June 1 of each year for all facilities.

For purposes of (1)(b), the "low income utilization rate" is calculated as follows: the total Medicaid revenues paid to the hospital in the hospital's qualifying year, plus the amount of cash subsidies for patient services received directly from Alaska state and local governments in the hospital's qualifying year, divided by the total amount of revenues of the hospital (including the amount of such cash subsidies) for the hospital's qualifying year; plus the hospital's charges for inpatient hospital services attributable to charity care for the hospital's qualifying year less the portion of any cash subsidies for patient services received directly from Alaska state and local governments attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the same period. For State facilities which do not have a charge structure, the hospital's charges for charity care are the cash subsidies received from Alaska state and local governments by the facility. The "low income utilization rate" will be calculated annually upon receipt from the facilities, relevant information necessary in determining the utilization rate.

As an example of determining eligibility, if the Alaska Medicaid inpatient utilization rate at one standard deviation above the mean Alaska Medicaid inpatient utilization for hospitals in Alaska is 32 percent, a facility with a Medicaid inpatient utilization of 32 percent or greater will qualify for a disproportionate share payment adjustment under (1) (a).

Alternatively, if another facility has a Medicaid inpatient utilization of 30 percent, it would not qualify for a disproportionate share payment adjustment under (1)(a), but could qualify under (1)(b) if its low income utilization rate exceeds 25 percent.

In addition, in order to qualify as a DSH ...ital must have a Medicaid inpatient utilization rate in its qualifying year ...imum of one percent.

(2) Payment Adjustment. (a) For those hospit... qualify for disproportionate share payment adjustments under (1)(a), t... mum payment will be one percent of allowable charges. This minimu... ent reflects a provider whose Alaska Medicaid inpatient utilization is at le... tandard deviation above the mean Medicaid inpatient utilization rate ...spitals receiving Medicaid payments in the State of Alaska. The dispro... te share payment adjustment will increase proportionately to the increa... edicaid inpatient utilization above the minimum level by one of two me... ected by the facility: (i) an additional one percent of charges for each p... ge point above one standard deviation above the mean Alaska Medicaid ... nt utilization rate; or (ii) an additional payment equal to 1.60% of the h... qualifying year Alaska state and local government cash subsidies for each ... age point above one standard deviation above the mean Alaska Medicaid ... ng year inpatient utilization rate.

For example, if the Medicaid inpatient utiliz... ne standard deviation above the state-wide mean is 32 percent and the h... utilization is 33 percent, the hospital may choose a disproportionate s... ayment adjustment to that hospital's Medicaid rate with a minimum ... of 1 percent of allowable charges and a choice of either an additional p... of: (i) 1 percent of allowable charges (for a total disproportionate share p... adjustment of 2 percent of allowable charges); or (ii) 1.60% times the ... state and local government cash subsidies paid to the hospital during th... al's most recently completed qualifying year. If the hospital's Medicaid in... utilization is 34 percent, the facility may choose, for its disproportionate s... ment, one of two methods to calculate its additional payment: (i) 3 perc... llowable charges; or (ii) 1 percent of allowable charges plus 3.2% of th... a state and local government cash subsidies paid to the hospital during th... al's most recently completed qualifying year. The payment adjustment is ... to a facility specific limit as described in this section at (11).

(b) For those hospitals that qualify fo... portionate share payment adjustments under (1)(b) but do not qualify ...)(a), the payment will be a minimum of one percent of allowable charge... inimum payment reflects a provider whose low income utilization r... t least 25 percent. The disproportionate share payment will increase ... onately to the increase in the low income utilization rate above the mini... el by one of two methods elected by the facility: (i) an additional perc... y which the hospital's low-

income utilization rate exceeds 25%; or (ii) an additional payment equal to 1.60% of the hospital's state and local government cash subsidies for each percentage point above 25%.

For example, if the hospital's low income utilization rate is 26 percent, the hospital may choose a disproportionate share payment adjustment to that hospital's Medicaid rate with a minimum of 1 percent of allowable charges and a choice of either an additional payment of: (i) 1 percent of allowable charges (for a total disproportionate share payment adjustment of 2 percent of allowable charges); or (ii) 1.60% times the state and local government cash subsidies paid to the hospital during the hospital's most recently completed fiscal year. If the hospital's low income utilization rate is 27 percent, its total disproportionate share payment will be the greater of: (i) 3 percent of allowable charges; or (ii) 1 percent of allowable charges plus 3.2% of the state and local government cash subsidies paid to the hospital during the hospital's qualifying year. This provision is intended to take into account the situation of public institutions that furnish services free of charge or at nominal charges. The payment adjustment is subject to a facility specific limit as described in this section at (11).

(3) Other Requirements. All hospitals qualifying for the disproportionate share must meet the criteria of having two obstetricians providing obstetrical services to Medicaid patients or in rural areas must have two physicians providing non emergency obstetrical services to Medicaid patients. Hospitals that do not offer obstetrical services as of December 22, 1987 will be exempt from this requirement.

(4) A qualifying hospital will receive an additional disproportionate share payment for exceptionally high costs or exceptionally long-stays for children under age six. Exceptionally high costs are those exceeding 150 percent of the mean costs per admission in the facility qualifying year for children under age six. Similarly, exceptionally long-stays are those exceeding 150 percent of the mean days per admission in the facility qualifying year for children under age six. The additional disproportionate share payment will be 100 percent of the hospitals disproportionate share rate determined in (2) (a) or (2)(b), subject to the facility-specific limit explained in (11) of this section. This payment will be made only if the facility provides documentation satisfactory to the department that these criteria have been met.

(5) Out-of-State hospitals providing inpatient services to Alaska Medicaid recipients and who have a disproportionate share of Medicaid patients may request to receive a payment adjustment relative to the methods and standards in (2)(a) and

(2)(b) above. If an Out-of-State hospital does request a DSH adjustment, they must supply all necessary data in order for the State to complete the calculations.

(6) All facilities that qualify under (1)(a) or (1)(b) of this subsection receive a minimum 1% add-on to their reimbursement rate for allowable charges. This add-on is paid each time a claim is processed. Under sections (2), (4), and (5) of this subsection, facilities may also choose to receive DSH payments in either an annual lump sum payment, based on qualifying year information, or as a percentage add-on to the payment rate paid on claims processed through out the rate year.

(7) The percentage of disproportionate share payment is not subject to the limitations of 100% of charges.

(8) The total disproportionate share payments to all hospitals in the aggregate will be limited to the Federal disproportionate share cap established for the State of Alaska. A comparison of the Federal cap to the State's estimated total disproportionate share payments for the federal fiscal year will occur before any payments are distributed to qualifying hospitals.

(9) If the State's estimated total disproportionate share payments exceed the Federal cap for those payments, the State will proportionately reduce the disproportionate share payments to be made to facilities in the state.

(10) The State will recalculate and reallocate the disproportionate share eligibility and payments for all hospitals and will recoup payments from all hospitals on a prorated basis if the disproportionate share eligibility and payment for any hospital must be recalculated as a result of a final commissioner's decision in an administrative appeal or of a court decision that would cause the total disproportionate share payments to exceed the federal allotment and/or the IMD cap for the federal fiscal year in which the payment rate was in effect.

(11) Facility Specific Limit - Hospitals' DSH payments are limited to: The Cost of Services to Medicaid patients less the amount paid by the State under the non-DSH payment provisions of the State Plan; plus the Cost of Services to Uninsured Patients less any cash payments made by them or on their behalf for those services.

An Uninsured Patient is defined as an individual who's costs are not met because they have no insurance or other resources.

Cost of Services is total allowable costs of the hospital as defined in the State Plan divided by total patient days of the hospital times Uninsured Patient Days or Medicaid Patient Days as applicable.

(12) This section outlines methods and standards for calculating a disproportionate share adjustment to each prospective payment year beginning during the period this plan is effective. For purposes of making the DSH calculations in this section, a "Qualifying" year means a hospital's base year for its prospective rate year beginning immediately after the qualifying date of June 1 of each year. The base year is the hospital's fiscal year ending 24 months before the prospective rate year.

XII. Exceptional Relief to Rate Setting:

If the rate setting methodology results in a permanent rate which does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the deputy commissioner of the department for exceptional relief from the rate setting methodology. This provision applies to situations where a facility is forced to close or dramatically reduce quality of care to its residents due to the inadequacy of its payment rate. To apply for exceptional relief, the facility's application should include:

1. the amount by which the facility estimates that the rate should be increased to allow reasonable access to quality patient care provided by an efficiently managed facility;

2. the reasons why and the need for exceptional relief requested, including any resolution by the facility's governing body to support the reasons offered, and why such a rate increase cannot be obtained through the existing rate setting process;

3. the description of management actions taken by the facility to respond to the situation on which the exceptional relief request is based;

4. the audited financial statement for the facility for the most recently completed facility fiscal year and financial data, including a statement of income and expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;

5. a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;

6. an analysis of community needs for the service on which the exception request is based;

7. a detailed analysis of the options of the facility if the exception is denied;

8. a plan for future action to respond to the problem; and

9. any other information requested by the deputy commissioner to evaluate the request.

The deputy commissioner may request recommendations from the Commission on a facility's application for exceptional relief. The deputy commissioner may increase the rate, by all or part of the facility's request if the deputy commissioner finds by clear and convincing evidence that the rate established under section IV. and V. of Attachment 4.19-A does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest. In determining whether the exception is in the public interest, the deputy commissioner may consider at least:

1. the necessity of the rate increase to allow reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;

2. the assessment of continued need for this facility's services in the community;

3. whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;

4. the recommendations, if any, from the Commission;

5. the availability of other resources available to the facility to respond to the crisis;

6. whether the relief should have been obtained under the existing rate methodology;

7. other factors relevant to assess reasonable access to quality patient care provided by an efficiently and economically managed facility.

The deputy commissioner will impose conditions on the receipt of exceptional relief including, but not limited to the following:

1. the facility sharing the cost of the rate exception granted;

2. the facility taking effective steps in the future to alleviate the need for future requests for exceptional relief;

3. the facility providing documentation as specified of the continued need for the exception; or

4. a maximum amount of exceptional relief to be granted to the facility under this section.

Amounts granted as exceptional relief shall not be included as part of the base on which future prospective rates are determined. Exceptional relief shall be effective prospectively from the date of the exceptional relief decision and for a period of time not to extend beyond the facility's rate setting year. A facility may apply for and be granted exceptional relief in the following year. A party aggrieved by a decision of the deputy commissioner concerning exceptional relief may request an administrative hearing to the commissioner of the department.

XIII. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.